Children's Disability Services Workgroup

Meeting #2
October 15, 2013, 10:00 am – 3:00 pm
Polk County River Place, Room 2
2309 Euclid Avenue
Des Moines, IA 50310

MINUTES

ATTENDANCE

Workgroup Members: Jim Ernst, Chuck Palmer, Marilyn Althoff, Gail Barber, Nicole Beaman, Dana Cheek, Paula Connolly, Deb Dixon, Patty Erb, Jason Haglund, Sheila Kobliska, Janice Lane, Marilyn Lantz, Scott Musel, Amber Rand, Wendy Rickman, Jason Smith, Shanell Wagler, Debra Waldron, Susan Walkup,

Legislative Representation: Senator Nancy Boettger

Workgroup Members Absent: Jerry Foxhoven, Nick Juliano, Representative Lisa Heddens, Representative Joel Fry, Senator Liz Mathis

Facilitator: Kevin Martone and Kelly English

DHS/IME Staff: Laura Larkin, Don Gookin, Sally Nadolsky, Carmen Davenport, Theresa Armstrong

Other Attendees:

Sue Lerdal	
Josh Bronsink	Senate Republicans
Chaney Yeast	Blank Children's Hospital
Susan Osby	Polk County Health Services
Arnie Honkamp	DHS
Karen Bougher	Polk County Health Services
Melissa Havig	Magellan
Sheila Hanson	CFPC
John Pollack	LSA
Kristie Oliver	Coalition for Family & Children's Services
Ann Riley	CDD
Beth Rydberg	DRI
Melissa Fitzgerald	Sequel Youth Services/WACBS

Brice Oakley	AOC, IACMHD, and Orchard Place
Rhonda Rairden	IDPH
Mike Heller	
Susan Fenton	LSI Group
Paula Feltner	
Vickie Miene	Center for Child Health, UIHC

INTRODUCTIONS AND WELCOME
Jim Ernst asked workgroup members and guests to introduce themselves.

Nicole Beaman distributed a handout from the ACES Conference held in Des Moines on 10/14/13. Nicole provided a brief explanation of the conference, and asked others to contact her if anyone had questions about the handout.

MEETING #1 MINUTES
Jim Ernst asked workgroup members to review the minutes from the first meeting held on October 1, 2013. The meeting minutes were accepted as written.

CHILDREN'S MENTAL HEALTH SYSTEM CORE SERVICES DISCUSSION
Kevin Martone and Kelly English welcomed the workgroup members and guests, and provided highlights from the previous meeting.

Kevin highlighted the high level overview of other states' examples of mental health services, including Integrated Health Homes (IHH) as presented by Jennifer Vermeer during the first meeting. Kevin shared that this short workgroup process is to develop concrete recommendations to implement a system of care for children/youth as part of the Iowa Mental Health Redesign.

Kevin began the discussion by comparing adult core services to children core services and by asking workgroup members to identify minimum core services within this system. The core services may not be the full gamut of the services the workgroup may want initially.

The children's core services will have a similar framework as the adult core services ~ similar domains and minimum core services. Workgroup members were asked to review the handouts provided as a springboard to discussion. One workgroup member noted that education was not listed as a domain. Adults have employment, and education would be the expectation for children/youth. There are school-based therapy programs in Iowa. Kevin reported that education was left off as a domain as the minimum core services were being viewed through a mental health lens. Chuck Palmer reported that the creation of the Children's Cabinet would include a representative from education.

The Children's Mental Health System Core Services may be different than the adult core services and structure of the regions. Chuck reported that in Iowa we have the counties and the previous funding stream was via levies and state funding. The expectation was that the counties would provide mental health services, primarily to individuals with an Intellectual Disability (ID) and Mental Illness. Very few counties got

into providing services to children. Some counties did serve youth with ID and Developmental Disabilities (DD). There was unevenness in the level of services provided; this lead to core services that would be available to all individuals. Counties are in the process of developing regions, and the regions are in the process of pulling together to develop core services in the regions. County supervisors still make primary decisions within counties. The interface of the System of Care (SOC) and education will take place if the Children's Cabinet is formed. The SOC developed by this workgroup in 2012 is being delivered through the IHH at Magellan. The expansion of the Affordable Care Act (ACA) will have more individuals who will qualify for Medicaid. Iowa Medicaid is taking applications via the portal.

Workgroup members shared the following comments ~

- Workgroup member is concerned about open ended services, and would like to see employment addressed for youth. The schools also need flexible monies to provide services when youth are in crisis.
- Workgroup member was struggling with the health and primary care as it is separated from prevention and wellness. It is hoped that this is being looked at from an overarching lifespan perspective ~ ages 0-21. As far as education is concerned, the broader Children's Cabinet will address education but the core services need to address education, transition, and employment supports for youth.
- Home and vehicle modification are noted for adults but not youth.
- Acute and sub-acute treatments are separate on the handout, and could be lumped together.
- A recommendation to use sub-acute vs. community-based residential treatment.
- There is a need to develop services for a child/youth that cannot remain in the family home, such as a host home.
- This is being looked at through the level of care need for the child as they enter the system, and children/youth enter the system at different times. Care coordination is not a domain, but is actually a service. IHH has care coordination and it is a service. There is a need to have a response plan to use when a child/youth is in crisis in a school setting. Many of the domains could be services. The Massachusetts model views it from the acuity of the child/youth vs. actually having services. Take the domain framework and identify domains in terms of acuity, and identify services using the SOC philosophy.
- List the domains starting with the least restrictive area and arrange in order.
- The domains will have to work with mental health and DD populations.

Kevin reported the system is designed to help children/youth and it becomes operationalized by providers. The system is operationalized and it looks at the child/youth and family needs. We have to make sure on paper that these services are available, and paid for by someone. These services need to be covered when a child/youth needs them. There are some details that need to be flushed out as a way to identify specific services. There is a need to have the basic minimum of services under the SOC that are available to youth statewide. The role/purpose of the domains is to provide a framework of core services and a range of recovery oriented services.

Kevin reported he and Kelly will work on revising the Iowa Youth Proposed Core Service Domains and Core Services handout and have it available for discussion after the break.

CHILDREN'S MENTAL HEALTH SYSTEM CORE SERVICES RECOMMENDATION

Kevin opened the discussion with the revised handout on Iowa Youth Proposed Core Service Domains and Core Services. Workgroup members suggested the following core services under each domain ~

Youth Core Service Domains	Youth Core Services
Prevention, Early Identification, and Early Intervention	• Psychiatric and Specialty Consultation model to Primary Care • Developmentally appropriate screening available through various settings, including but not limited to primary care, school, child care, etc. • Assessment • Home Based Health Supports (this would include nurses) • Home Visits • Medical Home • Mental Health and Substance Use Education
Mental Health and Substance Abuse Treatment	• Assessment and Evaluation • Medication Prescribingvand Monitoring • Access and availability to medications • Mobile Crisis Intervention and Stabilization including 24 hour Crisis Hotline • Acute and Sub-Acute Services 1. 23 Hour Crisis Stabilization 2. Crisis Residential 3. Inpatient Treatment • PMIC • Other Residential • Integrated Health Homes (IHH) • Care Coordination • Outpatient Treatment in a variety of settings such as 1. Individual, Group, and Family Counseling 2. In Home (mobile) Counseling 3. In Home Behavioral

	Management Therapy and Aide 4. Intensive Outpatient 5. Partial Hospitalization 6. Evidenced-Based Therapies • Mental Health and Substance Use Education
Recovery Supports	• Transition-Age Youth Services • Transition Services to a lower level of care and/or adult services • BHIS/Therapeutic Monitoring (e.g. community-based skill building and/or recovery coach) • Family and Peer Support • Respite • Integrated Health Homes (IHH) • E-Health Strategies ~ text messages, chat groups, email, etc.
Community-Based Flexible Supports	• Services and supports as identified in a plan of care for child/youth receiving services through an IHH • Educational and Employment Related Supports

During the break, a workgroup member drew an illustration of how the framework of core services would work and how maintenance is woven throughout the framework. This was explained to the workgroup.

This is a transformative process once the core services are identified. Care coordination is embedded into all the domains. It is an expectation of the system and is not a separate service. Core services also need to use evidenced-based practices.

Other key points of discussion are as follows ~

- If we use IHH, we need to be specific to what we need. We need to make sure we include the DD population as well as the SED population.
- Be cautious when we say a core service, and avoid being too detailed in the final report as some communities will not be able to replicate some services with details. It is a balance of striving to make core services available, and having evidence-based core services.
- Breakout services and include community services on the list. Kevin reported this could be a task for the Children's Cabinet but not this workgroup.
- Under Recovery Supports, we need to recognize other types of therapies that the DD population needs, such as PT, OT, Speech, movement, etc. Kevin reminded the workgroup that it needs to view the core services through a mental health lens.

- The core services need to be viewed from a disability perspective and not specific to mental health.
- Focus on continuity of care within each domain, and this will set the standards for private insurance to fund the same services.
- Focus on the Health Homes model developed last year that identifies when a child/youth needs a Primary Health Home, an Integrated Health Home, or a Specialized Health Home. It will be important to separate out each health home in the core services.
- It was suggested that the domains be separated out by child/community/state, and referenced the concentric circles of SOC from previous workgroup meetings.

Kevin asked the workgroup members to begin thinking how this information will be presented in the final report. Kevin posed questions like ~

- Do you still cite Health Homes as a service that can support an individual, and cite the expectation of the service?
- How does DHS describe Health Homes in Iowa Administrative Code (IAC)?

Chuck asked the workgroup to identify any services that were missing from this list. Chuck also mentioned that this needs to be broad for the legislature. IAC would then get more specific on service expectations, how to get the services to the community level, and funding. The Children's Cabinet will focus on operationalizing the core services.

STANDARDIZED ASSESSMENT DISCUSSION AND RECOMMENDATION

Kelly English began the discussion about using a standardized assessment in Iowa. Kelly asked a number of questions to consider when thinking about the use of a standardized assessment ~

- How do we implement this process and who do we bring to the table to adopt an assessment tool?
- What type of information do you want to collect?
- Who will do the training on the standardized assessment?
- Who will do the compliance monitoring with providers?
- Does it make sense for Iowa to have a standardized assessment tool to use with children/youth?

Kelly reported the examples listed on the handout ~ CASII, CANS, and CAFAS ~ are examples of assessments used by a mental health clinician. THE CASII and CAFAS are used in pockets of Iowa. These assessment tools would be used in addition to the assessments used in mental health clinics. This would provide a comprehensive assessment of a child's strengths/needs. This is used as part of the treatment planning process, quality assurance mechanisms, and tracking outcomes over time. These assessments are specific to different age ranges.

The benefits of having a standardized assessment tool would be ~

- It would help providers understand a youth better.
- It starts to help build the data set on who is being served, identifying system gaps, etc.

There is no standardized assessment tool in Iowa at this time. A workgroup member who is a provider reported they try to get records from previous providers. Having a standardized assessment tool would help agencies gather data. The CANS and the CAFAS can be completed by BA level staff. This workgroup member believes there are better assessments out there to help all providers to use/talk the same language. Magellan has a tool that gets consumer satisfaction as part of the standardized data collection process. The handout had additional information that may not pertain to Iowa but it needs to be considered as the workgroup moves forward.

Kevin asked the workgroup if an assessment tool exists that captures the information you want to measure/receive at the state level. Chuck reminded the workgroup of the need to take a holistic responsibility for a set of individuals across a full range of medical/mental health needs. Data will be tracked on these individuals. The quality of the outcomes and ability to show they have made a difference in care coordination is important. If the mental health world is to be part of this process, the legislature wants greater accountability. Key to the successful passing of the redesign was the focus on outcomes. The workgroup's job is to have a common language to use, define different terms, etc.

Nancy Boettger reported that many in the legislature see this whole arena as a black hole that drains budget dollars. The workgroup will have to sell this whole idea to the legislature. The idea is to spend resources now and how this will keep individuals from a higher level of care. The focus is on cause and effect over time. It will be important for the data from individual state departments to show a linkage to each other.

Kevin stressed the importance of building on the outcomes to get the long term goal of showing cause and effect over time. It will be important to put markers into the system to start the process. Kelly thought it would be good to select a broad assessment tool to start the data collection. Other assessment tools can be added in the future, and can be specialized.

Kevin spoke about what it was like for the state of Massachusetts to be court ordered to use a standardized tool. Kelly reported Massachusetts used the CANS and providers were resistant to using it initially. Providers had their own tools that they liked and did not want to give them up. Training was provided across the state of Massachusetts focusing on levels of care, funding and reimbursement, etc. Some providers grew to like the tool over time. Data entry into the IT system was problematic initially as the IT system had problems.

Chuck reported that if we are in the market to move forward with mental health services and documenting outcomes. We need to start at the individual level and then aggregate up to move across systems that individuals access. On the front end, we have to have an assessment that is objective and then tracking outcomes that will eventually drive funding. It will take time for the legislature to agree on a standardized assessment. We will have to overcome the historical resistance of the provider network to use other assessments. We will find legislative champions to move this forward.

Workgroup members expressed the following thoughts about using a standardized assessment tool ~

- DHS uses the NCFAS. The DHS spends a great deal of time looking at the domains. There is value in deciding that a standardized assessment tool will be used. The purpose of using the NCFAS is to have statewide data. The workgroup needs to come to an agreement on using a standardized assessment tool.
- Do we want to name the tool or to figure it out by describing what we want in a tool?
- Substance abuse assessment tools are used to report data to IDPH. The IDPH has a central repository for the data that comes from directly reporting information or from electronic medical records (EMRs). The standardized assessment tool will need a common language to use statewide. We need outcomes but deciding on a tool will be very important.
- It is a challenge to have a provider focus on an identified risk factor even after multiple assessments.
- A local hospital uses an assessment tool to determine what level of care coordination a patient might need in terms of follow-up during recovery.
- Pediatric Health Home has a specific risk assessment tool that is tracked over time that focuses on System of Care (SOC) domains and outcomes for each child/youth. This tool provides standardization. The CANS and CAFAS tools are used to measure how children/youth are doing individually. It would be good to look at what is already being sued by the SOC, which Iowa has already funded. The data from this tool is collected/stored in a central repository.

Chuck shared that the workgroup is not being pushed to use a specific tool. Chuck also reported that a specific workgroup could decide on the standardized assessment tool and link input to a central repository. Jim emphasized the need to start someplace on identifying a tool to get to outcomes as outcomes drives funding.

PUBLIC COMMENT

Comment: The workgroup is doing important work. It is encouraging to hear that early identification and early intervention are in the domains. It is important to take steps to see data across various departments/service delivery systems. This workgroup's endeavors will be supported when the legislature reconvenes. This workgroup is a trendsetter in this area.

WRAP UP AND ADJOURN

- Workgroup members were asked to review the framework of the Youth Core Service Domains and the Youth Core Services under each domain. Workgroup members were asked to view the domains/services from the area they live in now, and how these domains/services could be fulfilled their area.
- TAC staff will identify the functions of a standardized assessment expressed during the meeting. TAC staff will keep in mind the tenets of ACO, and the different delivery systems under each domain. The delivery systems need to be very broad.

****Next meeting: October 29, 2013 from 10:00 am to 3:00 pm at Polk County River Place, Room 2, 2309 Euclid Avenue, Des Moines, IA 50310.**